Kansas
Department for Children and Families
Economic and Employment Services
Strong Families Make a Strong Kansas

ES-1653
Rev. 12-14

Out of Home Relative Provider Enrollment

Thank you for your interest in becoming a DCF child care provider for related families who may be eligible for DCF Child Care Assistance. As a relative, you are not regulated by the Kansas Department of Health and Environment (KDHE). DCF must take certain steps in order to ensure the health and safety of the children in your care who are funded through the Child Care Assistance Program. Parent participation is required to complete this enrollment. A relative provider must have a checking account, savings account or pre-paid debit card to receive EBT payments from parents who receive DCF subsidies. Prior to completing the enrollment, read and make sure you understand the DCF Child Care Provider Handbook.

Please return completed enrollment to: _____

_____

_____

Please return by: _____

Note: As an Out-of-Home Relative child care provider, you are enrolling to provide care for the children in one specific family. To provide care for any other children would require a separate enrollment.

DCF OUT OF HOME RELATIVE PROVIDER APPLICATION

Section 1:

Provider Information:

Name (first, middle, last): _____

SSN: _____ Date of Birth: _____ Gender: _____

Race: _____ Hispanic/Latino? _____

Are you a high school graduate or do you have a GED? _____

Primary Language Spoken: _____ Written: _____

Street Address: _____ City: _____

County:_____State:_____Zip:_____

Mailing Address:_____City: _____

County:_____State:_____Zip: _____

Primary Telephone Number:_____Alternate Telephone Number: _____

Email Address: _____

Parent of children for whom you will be caring:

Name of Child's Parent/Guardian: Parent's SSN:

Parent's Primary Languages Spoken:_____Written: _____

Provider Relationship to Children:_____Date Care Began: _____

Street Address:_____City: _____

County:_____State:_____Zip: _____

Mailing Address:_____City: _____

County:_____State:_____Zip: _____

Primary Telephone Number:_____Alternate Telephone Number: _____

Email Address: _____

Children for whom you will be caring:

Child Name	Date Care Began	Times of Care

Background Check: DCF records are checked for any history of child abuse or neglect. DCF checks the name(s) of the out of home relative provider and all household members ten (10) years of age or older. Each name must be cleared before approval for payment begins. A provider is not eligible to be approved if the names of any of the persons living in their home appear in the Child Abuse-Neglect Registry, the Adult Abuse, Neglect or Exploitation Registry or the Kansas Adult Supervised Population Electronic Repository (KASPER), or if he or she has felony convictions.

List all persons living in your household, including yourself:

Last Name	First Name	Middle Name	Maiden Name	Aliases	SSN	Date of Birth	Role (Relationship to Provider)

Has anyone who lives, works or volunteers in your home/facility been convicted of a felony? _____

If yes, provide name of person, date and court of action, county and state: _____

_____

Please go to the next page for statement review and signature.

Read the following statements and check if you agree:

_____I/We declare, under penalty of perjury, that to the best of my (our) knowledge, the information provided in this application is true and correct.

_____I understand that the terms listed in the DCF provider handbook and child care provider agreement (including Section 9) are incorporated into my provider agreement with DCF and are legally binding. My signature on this application certifies that I have read and understand those terms and agree to them.

_____I/We the undersigned are the person(s) named as the Applicant or the person(s) authorized to represent the owner listed above.

Print Provider Name	EES Designee Name
Provider Signature and Date	EES Designee Signature and Date

Submit this completed form along with a signed Policy Statement on Discipline and a signed (by both parent and provider) Health and Safety Standards – Home Checklist (forms in handbook).

FOR AGENCY USE ONLY:

Agreement Start Date: _____ End Date: _____

County Code:_____Provider ID: _____